MEDICARE

Coverage of Kidney Dialysis and Kidney Transplant Services

A Supplement to Your Medicare Handbook

PUBS
RA
645
K5
M43
1996

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

#7

CMS Library
C2-07-13
7500 Security Blvd.
Baltimore, Maryland 21244

RA
645
.K5
M43
1996

Contents

Medicare and Treatment for Permanent Kidney Failure 1

The Two Parts of Medicare 1
- Hospital Insurance (Part A) 1
- Medical Insurance (Part B) 2

Enrollment in Medicare for People with Permanent Kidney Failure 2

When Medicare Protection Begins 2

When Medicare Protection Ends 3

Medicare Payment for Beneficiaries Covered by Employer Group Health Plans 3

Providers of Maintenance Dialysis and Transplant Surgery 4

Coverage of Maintenance Dialysis 5
- Outpatient Dialysis 5
- Inpatient Dialysis 6

Doctor's Services and Maintenance Dialysis 6
- Outpatient Doctor's Services 6
- Inpatient Doctor's Services 6

Self-Dialysis Training 6

Home Dialysis 7
- Payment Options Under Home Dialysis 7
  - Method I: The Composite Rate 7
  - Method II: Dealing Directly with a Supplier 8
- Home Dialysis Equipment 8
- Home Dialysis Supplies 8
- Home Dialysis Support Services 9

Kidney Transplant Surgery 9
- What Hospital Insurance (Part A) Pays For 9
- What Medical Insurance (Part B) Pays For 9

How Medicare Pays for Blood 10

What Medicare Does Not Cover 11

Other Payment Sources 11

If You Have a Complaint 11

For Additional Help 11

ESRD Network Organizations 12

Medicare and Treatment for Permanent Kidney Failure

This supplement to *Your Medicare Handbook* explains the special rules that apply to Medicare coverage and payment for maintenance kidney dialysis and transplant services. People who have permanent kidney failure (End Stage Renal Disease or ESRD) can get these services.

Medicare also helps pay for a wide range of other health services and supplies. *Your Medicare Handbook* describes the other health services and supplies that are covered by Medicare and how payments are made.

The Two Parts of Medicare

Hospital Insurance (Part A)

Hospital care: Medicare Part A covers medically necessary inpatient hospital care. Medicare helps pay for up to 90 days of medically necessary inpatient hospital care in each benefit period. Medicare will help pay for more days if you use all or some of your lifetime reserve days. (See below for an explanation of benefit periods and lifetime reserve days.)

From the first day through the 60th day in a hospital during each benefit period, Part A pays for all covered services except the Part A deductible. From the 61st through the 90th day in a hospital during each benefit period, Part A pays for all covered services except for a daily amount called Part A coinsurance.

Skilled nursing facility care: Under certain conditions, Medicare Part A helps pay for 100 days of post-hospital care in a skilled nursing facility. You pay no deductible or coinsurance for the first 20 days, but you do pay a daily coinsurance amount for days 21 through 100.

Home health care: Medicare Part A helps pay for medically necessary home health care. You pay no home health care deductible or coinsurance, except for 20 percent of the approved amount for

Benefit periods: The benefit period is a way of measuring your use of inpatient hospital and skilled nursing facility services under Medicare Part A.

Your first benefit period starts the first time you enter a hospital after your hospital insurance begins. A benefit period ends when you have been out of a hospital or other facility primarily providing skilled nursing or rehabilitation services for 60 days in a row (including the day of discharge). If you remain in a facility (other than a hospital) that primarily provides skilled nursing or rehabilitative services, a benefit period ends when you have not received any skilled care there for 60 days in a row.

There is no limit to the number of benefit periods you can have for hospital and skilled nursing facility care.

Reserve days: Medicare Part A includes an extra 60 hospital days you can use if you have a long illness and have to stay in the hospital for more than 90 days. These extra days are called reserve days. You have only 60 nonrenewable reserve days in your lifetime, and you can decide when you want to use them.

durable medical equipment.

Hospice care: Medicare Part A helps pay for up to 210 days of hospice care. When necessary, an extended period of coverage may be allowed. You pay no deductible; you pay a small coinsurance amount for outpatient drugs and respite care.

Medical Insurance (Part B)

Medicare Part B covers doctor's services, outpatient hospital services, outpatient physical therapy and speech pathology services, and many other health services and supplies.

Most of the services and supplies needed by people with permanent kidney failure are covered by Part B. Part B has premiums, deductibles and coinsurance amounts that you must pay yourself or through coverage by another insurer.

The first $100 in covered expenses is called the Part B deductible. You need to meet this $100 deductible only once during the year. The deductible can be met by any combination of covered expenses.

After you have paid $100 in Medicare-approved charges for covered medical expenses, Part B generally pays 80 percent of the approved charges for any additional covered services you receive for the rest of the year. You are responsible for the remaining 20 percent, your coinsurance.

See page 9 for more information about Medicare Part B payments.

Enrollment in Medicare for People with Permanent Kidney Failure

You are eligible for Medicare Part A regardless of your age if you require regular dialysis or have had a kidney transplant, and meet one of the following two requirements:

- You or your spouse have worked the required amount of time under Social Security, the Railroad Retirement Board, or as a government employee.
- You, your spouse, or dependent child are receiving or are eligible for Social Security or Railroad Retirement cash benefits.

You can enroll at your local Social Security office. You may also want to enroll in Medicare Part B when you enroll for Part A.

If you have had Medicare before you developed permanent kidney failure and have not signed up for Part B or if your Part B has stopped, you can apply for this protection now. If you already have Part B but are paying a premium penalty for late enrollment, your premium amount can be reduced to the current basic rate. Social Security can give you more information.

If you have permanent kidney failure you cannot join a Medicare managed care plan (HMO). However, if you develop permanent kidney failure after joining a managed care plan, the plan will provide, pay for, or arrange for your care.

When Medicare Protection Begins

When you are first enrolled in Medicare because of permanent kidney failure, your Medicare protection starts with the 3rd month after the month your course of maintenance dialysis treatments began.

For example, if you began receiving maintenance dialysis treatments in July, your Medicare coverage would start on October 1.

There are two ways your Medicare protection can begin earlier.

- Medicare coverage can begin in the *first month* of dialysis if:
  - — you participate in a self-dialysis training program in a Medicare-approved training facility,
  - — you start the training before the third month after dialysis begins, *and*
  - — you expect to complete the training and self-dialyze after that.
- Medicare coverage can begin *the month you are admitted* to an approved hospital for a kidney transplant or procedures preliminary to a transplant if:
  - — the transplant takes place in that month or within the two following months.

If your transplant is delayed more than two months after you are admitted to the hospital for the transplant or procedures preliminary to the transplant, Medicare will begin two months before the month of the transplant.

When Medicare Protection Ends

If you have Medicare **only** because of permanent kidney failure, Medicare protection will end 12 months after the month you no longer require maintenance dialysis treatments or 36 months after the month of a kidney transplant.

Note: Medicare coverage may be reinstated immediately without any waiting period if:

- You resume dialysis or get a transplant within the 12 month period after the month you stopped getting dialysis, *or*
- You begin or resume dialysis or get another transplant after the 36-month period after a transplant.

Your Medicare Part B can stop at any time if you fail to pay premiums or if you decide to cancel it.

Medicare Payment for Beneficiaries Covered by Employer Group Health Plans

Some Medicare beneficiaries are also covered by an employer group health plan. For these Medicare beneficiaries the employer plan is often the primary plan—that is, the employer plan pays first on the Medicare beneficiary's health insurance claims.

If you can get Medicare because of permanent kidney failure and are covered by an employer group health plan, Medicare will generally be your secondary payer during an 18-month coordination period. Employer coverage, based on your or a family member's employment, is always primary to Medicare during the 18-month coordination period. When employer coverage is based on retirement, it is primary to Medicare during the 18-month coordination period, as long as permanent kidney failure is the initial basis for Medicare entitlement.

The 18-month period in which Medicare is secondary begins the first month you are able to get Medicare because of permanent kidney disease—whether or not

you are enrolled. The 18-month coordination period applies, even for those people already enrolled in Medicare because of age or disability, when the employer's coverage is based on you or your spouse's current employment status (in the case of age), or you or your family member's current employment status (in the case of disability).

Since you usually cannot get Medicare until the third month after the month in which you start a regular course of dialysis, you would have only your employer group health plan coverage during the first 3 months of dialysis–unless you are already enrolled in Medicare because of age or disability. However, if you undertake a course in self-dialysis training or receive a kidney transplant during the 3-month waiting period, part or all of this initial 3-month period would be included in the 18-month period during which Medicare may be secondary.

Employer plans pay first for kidney treatment and other health services furnished during the 18-month period. However, if the employer plan doesn't pay in full, Medicare may make secondary payments to supplement the amount paid by the employer plan. At the end of the 18-month period, Medicare becomes the primary payer. If you are covered by an employer group health plan during the 18-month period, you should tell the person who furnishes you with medical services so that the services can be billed correctly.

If you have more than one period of Medicare enrollment based on kidney disease, there is a separate coordination period for each period of Medicare enrollment. For instance, if you receive a kidney transplant which is successful for at least 36 months, your Medicare protection ends as indicated above under *When Medicare Protection Ends*. If after the 36-month period you file for and again become enrolled in Medicare because you resume maintenance dialysis or receive another transplant, your Medicare coverage will be reinstated immediately, without a waiting period, and there will be a new 18-month coordination period if you are covered by an employer group health plan.

If your employer plan will pay for all your health expenses, you may wish to wait until the 18-month period is over to file for Medicare Part A and Part B enrollment. Delay in enrollment avoids making unnecessary Medicare Part B premium payments. Check with Social Security before you decide to delay enrollment to make sure the delay is wise in your case.

Providers of Maintenance Dialysis and Transplant Surgery

To receive Medicare payments, medical facilities must be specifically approved to provide maintenance dialysis or kidney transplant surgery—even if they already participate in Medicare to provide other health care services covered by the program.

They must meet special health, safety, professional and staffing standards directly related to dialysis and kidney transplant services. And they must meet applicable federal, state, and local requirements.

Your doctor or the facility can tell you

whether a facility is approved by Medicare for payment of maintenance dialysis or transplant services.

Coverage of Maintenance Dialysis

This section explains coverage and payment for outpatient maintenance dialysis and the conditions under which inpatient dialysis is covered.

Outpatient Dialysis

Medicare Part B helps pay for outpatient maintenance dialysis treatments in any approved dialysis facility. Your coverage includes the costs of equipment, supplies, certain laboratory tests and other services associated with your treatment. Part B payments for outpatient maintenance dialysis furnished in the facility are always made to the facility.

Medicare pays the facility for dialysis-related services based on a per treatment rate that is set in advance. This rate is the facility's **composite rate**. The facility may charge you only 20 percent of this rate. For example, if you have already met the $100 deductible and the composite rate is $130 per treatment, Part B pays the facility 80 percent of $130 (or $104). Medicare *cannot* pay the remaining 20 percent of the charge (or $26). You are responsible for the 20 percent coinsurance charge.

In addition to those dialysis-related services included in the composite rate, dialysis facilities may provide and bill separately for certain other services. Many of the laboratory tests you get, for example, may be included as part of the facility's maintenance dialysis services. But, if you need additional tests, they can be covered as facility services, independent laboratory services, or as outpatient hospital services. For the services not included in the composite rate, you are responsible for a 20 percent coinsurance charge.

For more information on covered services, see the sections on doctors services and outpatient hospital services in *Your Medicare Handbook.*

Dialysis Patients Who Travel: If you are a dialysis patient and plan to travel, you should make arrangements for dialysis care along the route of your trip *before* you travel away from your usual dialysis facility. You are responsible for ensuring that an approved dialysis facility along the way has space and time available for your care, and that the physician and other medical personnel at the facility have enough information about you to treat you properly. Your facility will assist you in making the necessary inquiries.

When you plan your trip, take into account the location of Medicare approved dialysis facilities. There are over 2,700 facilities around the country. Your facility, ESRD network (see page 12), or local organization should be able to help you get the names and addresses of those facilities.

NOTE: If you get your dialysis services either from a Method II supplier or from a health maintenance organization (HMO), ask your supplier or HMO to assist you in getting dialysis while on travel. You may be responsible for your own dialysis treatment costs.

In general, Medicare will pay only for hospital or medical care received in the United States.

Inpatient Dialysis

Generally, maintenance dialysis treatments are covered on an outpatient basis. But if you are admitted to a hospital because your medical condition requires the availability of other specialized hospital services on an inpatient basis, your maintenance dialysis treatments would be covered by Part A as part of the costs of your covered inpatient hospital stay. Please see *Your Medicare Handbook* for more information about the coverage of inpatient hospital care.

Doctor's Services and Maintenance Dialysis

Doctors services are covered by Medicare Part B. While you are on maintenance dialysis, Part B can pay for your doctor's services in the following ways.

Outpatient Doctor's Services

Medicare pays benefits for all doctor's services related to outpatient maintenance dialysis. Medicare carriers pay doctors on a monthly basis for the kidney disease-related services they provide to each patient. The same monthly amount is paid for each patient the doctor supervises, regardless of whether the patient dialyzes at home or as an outpatient in an end-stage renal disease (ESRD) facility. Using this method of physician payment, Part B pays 80 percent of the monthly fee, minus any part of the $100 deductible you have not met. If your doctor accepts assignment, Medicare payment is made directly to him or her; otherwise, you receive the payment.

Inpatient Doctor's Services

If you are hospitalized, your doctor has a choice of two methods of payment for furnishing services to you as an inpatient. Your doctor may choose to continue to receive the monthly payment, in which case you cannot be billed for any additional amounts. Or, your doctor can choose to bill separately for the inpatient services, which Medicare will pay for in the manner described in *Your Medicare Handbook*. In this case, your doctor's monthly payment will be reduced based on the number of days you are hospitalized.

Self-Dialysis Training

Self-dialysis training is covered by Medicare Part B on an outpatient basis.

Coverage of self-dialysis training includes your instruction and instruction for the person who will assist you with maintenance self-dialysis at home. Part B also covers the maintenance dialysis treatment and laboratory tests and other services and supplies associated with the treatment.

By law, Medicare *cannot* cover the cost of paid dialysis aides to assist self-dialysis patients at home. Nor can Medicare cover the costs of wages that you and your assistant lose while being trained, or the cost of lodging during treatment.

Payment rates for self-dialysis training sessions are higher than those for maintenance dialysis treatments. And charges vary from one dialysis facility to

another, depending upon type of facility and its geographic location. But regardless of variations in charges, this is how Medicare payment works: If you are charged $150 per session and have already met the annual deductible, Part B will pay 80 percent of the training rate (or $120 per session). Medicare *cannot* pay the remaining 20 percent (or $30 per session).

For the services of the doctor who is conducting your self-dialysis training, the maximum total charge Part B will approve is $500. If you have already met the Part B deductible and your doctor charges you $500, Medicare would pay 80 percent of $500 (or $400). Medicare *cannot* pay the remaining 20 percent (or $100), or any charges above the Medicare approved amount.

Retraining for self-dialysis—for example, in the use of new equipment—is also covered by Medicare Part B on an outpatient basis.

Home Dialysis

Medicare Part B covers home dialysis equipment, all necessary supplies, and a wide range of home support services. Home dialysis includes home hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD).

Usually, drugs used in your home are not covered unless a doctor administers them. However, certain drugs for home dialysis patients are covered even though a doctor is not present. The most common of these are heparin, the antidote for heparin when medically indicated, and topical anesthetics. In addition, Part B covers the self-administration of the drug Epoetin alfa (EPO), by you or your care giver, subject to standards established for this drug's safe and effective use. Blood or packed red blood cells *cannot* be covered for home dialysis unless your doctor administers it or personally directs its administration, or if the blood is needed to prime your dialysis equipment (see How Medicare Pays for Blood, page 10).

Payment Options Under Home Dialysis

If you dialyze at home, you can choose between two payment options: *Method I* or *Method II*. These options are described below. To make a choice, you complete the Beneficiary Selection Form HCFA-382, sign it and return it to the facility supervising your care. You can get a copy of Form-382 from your dialysis facility. Once you make your initial choice, you must continue under that option until December 31 of that year. You can change from one method to the other by filing a new Form-382 at any time, but the change does not go into effect until the following January 1. It is important to remember that choosing *Method I* or *Method II* does not in any way prevent you from returning to treatment in a center, selecting another kind of treatment for ESRD care, or choosing to associate with another facility.

Method I: The Composite Rate

If you choose *Method I* your dialysis facility is responsible for providing all services, equipment and supplies necessary for home dialysis. Medicare

pays the facility directly for these items and services at a predetermined composite rate. Under this arrangement, you are responsible for paying the $100 deductible and the 20 percent coinsurance on the Medicare rate to the facility.

Method II: Dealing Directly with a Supplier

If you choose *Method II*, you must deal directly with a single supplier to obtain all of your home dialysis equipment and supplies. Your supplier must have a written agreement with a dialysis facility to guarantee that you will receive all necessary backup and home dialysis support services. If your supplier does not accept assignment of Medicare benefits (Medicare's allowance for its charges), then Medicare will not pay anything, and you will be responsible for the supplier's entire bill. If your supplier accepts assignment, you are responsible for any unmet part of the $100 deductible and for 20 percent coinsurance of the approved charges for these items and services. There is a national payment limit under *Method II*, and no supplier may charge more than this limit.

Under both methods, you must receive your home dialysis support services from your facility, for which Medicare pays the facility directly.

Home Dialysis Equipment

Under *Method I*, all home dialysis equipment and equipment- related services are covered under the facility's composite rate payment. Under *Method II*, Part B also covers rental or purchase of dialysis equipment for home use. Delivery, installation and maintenance charges are included as part of this benefit.

Whether you rent or buy dialysis equipment, Part B usually makes monthly payments. If you buy dialysis equipment, the monthly Part B payment includes any reasonable interest or carrying charges that may be part of an installment purchase agreement with the supplier of the equipment.

After the $100 deductible, Part B pays 80 percent of the approved monthly rental charge or the approved monthly installment purchase price for your home dialysis equipment.

Part B payments for your home dialysis equipment can continue as long as you need to be dialyzed at home. If your need for home dialysis stops, Part B payments also stop. For example, if you no longer need to be dialyzed because your kidney transplant surgery was successful, then Part B payments for your home dialysis equipment would stop.

If you purchase your dialysis equipment, Part B payments always stop when the Medicare approved purchase price is reached.

Home Dialysis Supplies

Part B covers all supplies necessary to perform home dialysis. This includes disposable items such as alcohol wipes, sterile drapes and rubber gloves, forceps, scissors, and topical anesthetics. Under *Method I*, all home dialysis supplies are covered under the facility's composite rate payment. Under *Method II*, after the $100

deductible, Part B pays 80 percent of the approved charges for all covered items.

Home Dialysis Support Services

Part B covers periodic support services, furnished by an approved hospital or facility, which are necessary to help you remain on home dialysis. After your doctor approves the plan of treatment, such support services may include visits by trained hospital or facility personnel to periodically monitor your home dialysis and to assist in emergencies when necessary. Part B also covers the services of qualified facility or hospital personnel to inspect your dialysis equipment and to test your water supply.

Under *Method I*, all home dialysis support services are covered under the facility's composite rate payment. Under *Method II*, Part B pays directly to the facility 80 percent of the approved charges for all covered services after the $100 deductible has been met.

Kidney Transplant Surgery

Both parts of Medicare help pay for kidney transplant surgery.

What Hospital Insurance (Part A) Pays For

Medicare Part A covers your inpatient hospital services in an approved hospital when you are admitted for kidney transplant surgery. (See page 1 for more information about the Medicare inpatient hospital benefit.) Part A also covers hospital services in preparation for your kidney transplant. This includes the Kidney Registry fee and services such as laboratory and other tests that are required to evaluate your medical condition and the medical conditions of potential kidney donors. These preparatory services are covered whether they are done by the approved hospital where your transplant surgery will take place or by another hospital that participates in Medicare. If there is no kidney donor, the costs of obtaining a suitable kidney for your transplant surgery are also covered.

Part A pays the full cost of care for a person who donates a kidney for your transplant surgery. This includes all reasonable preparatory, operation, and postoperative recovery expenses connected with the donation. There is no deductible or daily amount for your donor's hospital stay. The inpatient hospital stay does not qualify your donor for any Medicare benefits not associated with the kidney donation. But, Medicare Part A will pay for any additional inpatient hospital care your donor might need if complications result directly from the kidney donation. Medicare does not pay for kidneys; the purchase of human organs is prohibited by law.

Medicare Part A payments are made directly to the hospital.

What Medical Insurance (Part B) Pays For

Medicare Part B covers your surgeon's services for performing the kidney transplant operation. This includes pre-operative care, the surgical procedure, and follow-up care. Part B also covers doctor's services provided to your kidney donor

during his or her inpatient hospital stay while you are receiving a kidney transplant.

After you meet the annual $100 Part B deductible, Part B pays 80 percent of the approved charge for your surgeon's services to you. You are responsible for the remaining 20 percent.

There are certain limits on the amount your doctor can charge you, even if your doctor does not take assignment. On unassigned claims, you are only responsible for the part of your bill that is more than the Medicare-approved amount—up to the limit Medicare allows your doctor to charge. Look in *Your Medicare Handbook* for more information about "assignment" and limits on charges.

There is no deductible or coinsurance for doctor's services provided to your kidney donor.

Following your discharge from a transplant hospital, Medicare pays for your immunosuppressive drug therapy. As of July 1, 1995, Medicare pays for your immunosuppressive drugs for a period of 36 months following your discharge. This benefit is subject to the Part B deductible and coinsurance provisions.

How Medicare Pays for Blood

Both parts of Medicare can help pay for whole blood or units of packed red blood cells, blood components, and the cost of blood processing and administration after the Part A and B blood deductibles are met.

Medicare Part A does not pay for the first three units of whole blood or units of packed red cells that you receive, during a benefit period, as an inpatient of a hospital or skilled nursing facility. You are responsible for the first three units of whole blood or packed red cells. You have the option of paying the hospital's charges for the blood or packed red cells or arranging for it to be replaced.

If you choose to have the blood replaced, you can arrange for another person or an organization to replace it for you. A hospital or skilled nursing facility cannot charge you for any of the first three pints of blood you have replaced or have arranged to replace. Also, if the provider obtained blood or red cells at no charge other than a processing or service charge, the blood or red cells is deemed to have been replaced.

If you have paid for or replaced some units of blood under Medicare Part B during the calendar year, you do not have to pay for or replace that number of units again under Part A.

Except for replaced whole blood or packed red cells, Medicare Part B does not pay for the first three units of whole blood or units of packed red cells that are furnished in a calendar year.

NOTE: The blood deductible does not apply to other blood components such as platelets, fibrinogen, plasma, gamma globulin, and serum albumin, or to the cost of processing, storing, and administering blood.

After you have met the $100 deductible, Part B pays 80 percent of the approved charges for blood starting with the fourth pint in a calendar year.

Medicare does not cover blood in connection with self-dialysis at home

unless it is provided as part of a doctor's service or is needed solely for the purpose of priming the dialysis equipment.

If you have paid for or replaced blood under Medicare Part A during the calendar year, you do not have to do so again under Part B.

What Medicare Does Not Cover

The following list shows some of the services and supplies that Medicare does not cover in connection with dialysis and transplant services. *Your Medicare Handbook* lists other services and supplies which are not covered by Medicare (see "What Medicare Does Not Cover").

- Ambulance or other transportation costs to a facility for routine outpatient maintenance dialysis
- Dialysis aides' services to assist in home dialysis
- Inpatient hospital and skilled nursing facility costs when the stay is solely for maintenance dialysis
- Lodging costs when an outpatient dialysis facility is not near your home
- Wage losses to you and your dialysis partner during self-dialysis training

Other Payment Sources

If you have health care protection from private health insurance, the Veterans Administration, the Indian Health Service, a federal employee's health plan, CHAMPUS, or another source, it also may help pay for services you need for the treatment of permanent kidney failure.

In most states there are agencies that help with some of the medical expenses Medicare does not cover. Some states have Kidney Commissions that assist people in meeting the expenses Medicare cannot pay. And most states have a Medicaid program that helps pay medical expenses in cases of serious financial need.

Under certain circumstances, employer group health plans, including federal employee health plans, will be required to pay their benefits before Medicare pays (see page 3).

If You Have a Complaint

If you have a grievance or complaint about the quality or adequacy of care you are getting, discuss your problem with your doctor, nurse or facility administrator first. If this discussion does not resolve your problem, you have the right to file a grievance with the ESRD Network in your area. You can find your Network in the listing beginning on page 12. Your social worker can also give you more information about how the Network grievance system works.

For Additional Help

If you have questions about kidney dialysis or transplant services in your area, contact your local Network Organization (see page 12).

If you have any questions about Medicare, contact your nearest Social Security office or the Medicare insurance carrier in your area. The carriers are listed in the back of *Your Medicare Handbook*, which is available from the Social Security office.

ESRD Network Organizations

The ESRD Network Organizations are established by law and are organized into 18 geographic areas throughout the United States, Guam, Puerto Rico and American Samoa. The Network Organizations, listed below, are comprised of hospitals, kidney dialysis units, transplant centers, medical professionals and patients. The organizations are responsible for developing criteria and standards for the quality and appropriateness of patient care; assessing the appropriateness of treatment methods for patients; and making sure that the Renal Registry is maintained.

States of Maine, New Hampshire, Vermont, Massachusetts, Connecticut and Rhode Island
(ESRD Network Organization No. 1)
ESRD Network of New England
PO Box 9484
New Haven, Connecticut 06534
(203) 387-9332

State of New York
(ESRD Network Organization No. 2)
ESRD Network of New York, Inc.
1216 Fifth Avenue
New York, New York 10029
(212) 289-4524

State of New Jersey and Territories of Puerto Rico and U.S. Virgin Islands
(ESRD Network Organization No. 3)
TransAtlantic Renal Council
Cranbury Plaza
2525 Route 130, Building C
Cranbury, New Jersey 08512
(609) 395-5544

States of Pennsylvania and Delaware
(ESRD Network Organization No. 4)
University of Pittsburgh Medical Center
200 Lothrop Street
Pittsburgh, Pennsylvania 15213-2582
(412) 647-3428

District of Columbia and States of Maryland, Virginia, and West Virginia
(ESRD Network Organization No. 5)
Mid-Atlantic Renal Coalition
1527 Huguenot Road
Midlothian, Virginia 23113
(804) 794-3757

States of Georgia, North Carolina and South Carolina
(ESRD Network Organization No. 6)
Southeastern Kidney Council, Inc.
Lake Plaza East
900 Ridgefield Drive, Suite 150
Raleigh, North Carolina 27609
(919) 876-7545

State of Florida
(ESRD Network Organization No. 7)
ESRD Network of Florida, Inc.
1 Davis Boulevard, Suite 304
Tampa, Florida 33606
(813) 251-8686

States of Alabama, Mississippi and Tennessee
(ESRD Network Organization No. 8)
Network Eight, Incorporated
PO Box 55868
Jackson, Mississippi 39296-5868
(601) 936-9260

States of Kentucky, Indiana and Ohio
(ESRD Network Organization No. 9)
Tri State Renal Network, Inc.
911 E. 86th Street, Suite 202
Indianapolis, Indiana 46240-1858
(317) 257-8265

State of Illinois
(ESRD Network Organization No. 10)
Crescent Counties Foundation for Medical Care
1001 Warrenville Road, Suite 500
Lisle, Illinois 60532-9735
(708) 769-9600

States of Michigan, Minnesota, Wisconsin, North Dakota and South Dakota
(ESRD Network Organization No. 11)
Renal Network of the Upper Midwest
970 Raymond Avenue, Suite 205
St. Paul, Minnesota 55114
(612) 644-9877

States of Missouri, Iowa, Nebraska and Kansas
(ESRD Network Organization No. 12)
ESRD Network Organization No. 12
North Point Circle II, Suite 105
7509 Northwest Tiffany Springs Parkway
Kansas City, Missouri 64153
(816) 880-9990

States of Arkansas, Louisiana and Oklahoma
(ESRD Network Organization No. 13)
ESRD Network Organization No. 13
625 NW 13th Street
Oklahoma City, Oklahoma 73103-2232
(405) 523-2127

State of Texas
(ESRD Network Organization No. 14)
ESRD Network of Texas, Inc.
1755 N. Collins Blvd., Suite 221
Richardson, Texas 75080
(214) 669-3311

States of New Mexico, Colorado, Wyoming, Utah, Arizona and Nevada
(ESRD Network Organization No. 15)
Intermountain ESRD Network, Inc.
Penn Center
1301 Pennsylvania Street, Suite 220
Denver, Colorado 80203-5012
(303) 831-8818

States of Montana, Alaska, Idaho, Oregon and Washington
(ESRD Network Organization No. 16)
Northwest Renal Network
2701 First Avenue, Suite 430
Seattle, Washington 98121
(206) 448-1803

Northern California, Hawaii, Pacific Trust Territory, Guam and American Samoa
(ESRD Network Organization No. 17)
TransPacific ESRD Network
25 Mitchell Blvd., Suite 7
San Rafael, California 94903
(415) 472-8590

Southern California
(ESRD Network Organization No. 18)
Southern California Renal Disease Council
6255 Sunset Blvd., Suite 2211
Los Angeles, California 90028
(213) 962-2020

★ U.S. GOVERNMENT PRINTING OFFICE: 1996 — 776 - 212 / 45058

CMS Library
C2-07-13
7500 Security Blvd.
Baltimore, Maryland 21244

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
7500 Security Boulevard
Baltimore, Maryland 21244

Publication No. HCFA 10128
Revised May 1996

Special Fourth Class Rate

HCFA
MEDICARE • MEDICAID
Health Care Financing Administration